The Doctrinal Basis for Medical Stability Operations

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ABSTRACT This article describes possible roles for the military in the health sector during stability operations, which exist primarily when security conditions do not permit the free movement of civilian actors. This article reviews the new U.S. Army Field Manuals (FMs) 3-24, Counterinsurgency and FM 3-07, Stability Operations, in the context of the health sector. Essential tasks in medical stability operations are identified for various logical lines of operation including information operations, civil security, civil control, support to governance, support to economic development, and restoration of essential services. Restoring essential services is addressed in detail including coordination, assessment, actions, and metrics in the health sector. Coordination by the military with other actors in the health sector including host nation medical officials, other United States governmental agencies, international governmental organizations (IGOs), and nongovernment organizations (NGOs) is key to success in medical stability operations.

INTRODUCTION

Where there is need, health sector development generally is conducted by development experts and other nonmilitary organizations. Where conditions are violent, such as hostile counterinsurgency, the military may be the only organization capable of action in any sector, including health. Thus, in stability operations it sometimes befalls the military to engage the local health sector and establish the foundation for greater success by civilian agencies and organizations as the environment stabilizes and permits greater freedom of action.

Medical stability operations are the conduct of stability operations in the health sector, whether or not this includes military engagement with the health sector. Successful medical stability operations support health delivery by the host nation and focus on increasing governmental legitimacy. They have value as a strategic communications tool to clarify intentions to local leaders and citizens by serving the local populace, create an "in" for United States stability operations, and seize the initiative in perception.

In the military, U.S. Army Reserve civil affairs units have the doctrinal responsibility to conduct planning for medical stability operations.[1] However, military medical personnel are often integrally involved in medical stability operations and should understand how military stability tasks are related to the Department of State's stability sectors in the essential stability task matrix (see Figure 1). A single model should be developed along logical lines of effort and is essential to achieving unity of effort with other actors on the battlefield. Military medical professionals should have a thorough understanding of counterinsurgency and stability operations to contribute to successful full spectrum operations. Lack of understanding may lead to useless or dangerous activities that result in counterproductive operations or worse, including needless loss of life.

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Stability Operations

Legitimacy is central to building trust and confidence among the local people in stability operations. It is characterized essentially by a government that responds to its citizens. Building institutional capacity, with education and training at the heart of development efforts, enables good governance and increases legitimacy. Thus capacity building is fundamental to success in stability operations.

In stability operations where the United States government (USG) is decisively engaged, permissive environments may exist that allow free movement of civilian personnel and resources. In these cases, there will often be many civilian agencies engaged in all spectrums of development. In the health sector, this includes host nation (HN) medical assets, other USG actors such as the United States Agency for International Development (USAID), international government organizations (IGOs) such as the World Health Organization and the World Bank, and nongovernment organizations (NGOs) such as International Medical Corps and many others. Military medicine's role in permissive environments may simply be to seek visibility of others' efforts and to be ready to help if asked. Military medical assets may be fully deployed in disaster or humanitarian assistance settings but generally military medicine will not be engaged in health sector development in mature, stable environments.

In nonpermissive environments such as active insurgency or civil war, civilian actors may be highly constrained and unable to affect health sector development because of security issues. When this is the case, it may be more important to do what is needed than who does it. U.S. military medical personnel and assets may be required to engage in any or all stability sectors depending on the mission and environment. Medical stability operations are the conduct of stability operations in the health sector.

Essential Stability Tasks

Success in stability operations often depends on the commander's ability to identify the tasks essential to mission success.

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Essential stability tasks help commanders identify those tasks most closely related to mission success and to prioritize and sequence performance of those tasks with available combat power. Essential stability tasks are the essential tasks required to establish the end state conditions that define success and lay the foundation for success in stability operations.

In counterinsurgency, commanders link essential stability tasks to logical lines of operations to visualize, describe, and direct operations. Success in one line of operation reinforces success in the others. Progress along each line of operations contributes to attaining a stable and secure environment for the host nation (see Figure 2).

The essential stability tasks in the U.S. Department of the Army Field Manual (FM) 3-07, Stability Operations, describe health sector development tasks in the military's logical lines of operation. An approach that integrates the myriad actors in health sector development, including indigenous populations and institutions (IPIs), IGOs, NGOs, and other government agencies (OGA), will be most successful if planned and executed at all echelons from combatant commands down to the company level or below. Military medicine may have a role in executing essential stability tasks but its primary mission remains to provide U.S. forces with combat health support.

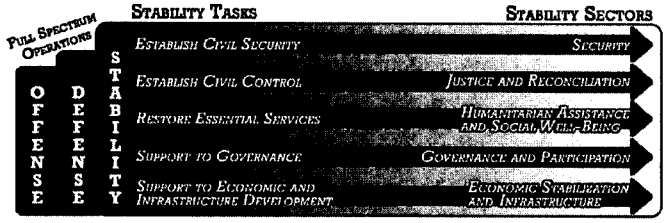

FIGURE 1. An integrated approach to stability operations.[17]

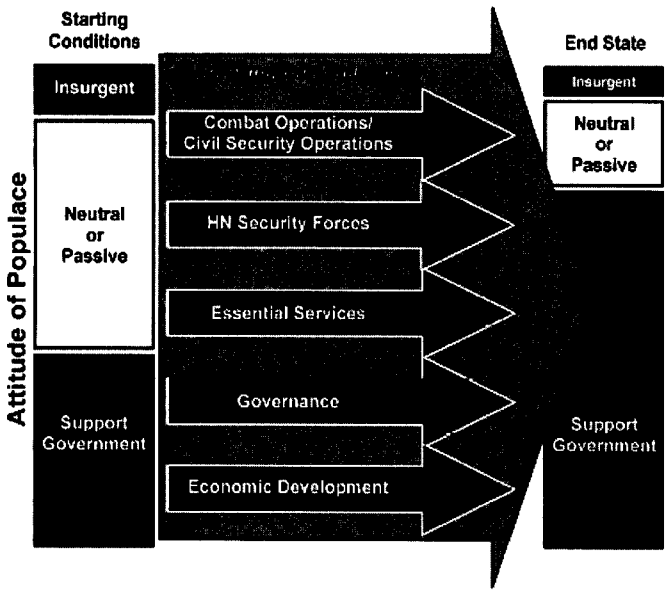

FIGURE 2. Example logical lines of operation for a counterinsurgency.[20]

Information Operations

In counterinsurgency, information operations may be the decisive line of effort by significantly contributing to the conditions for success in all other sectors.[2] Information operations are deliberately integrated with activities to complement and reinforce the success of other operations. Stability tasks that improve the safety, security, and livelihood of the populace help shape their perception that supporting their government is in their best interest.[3] Sometimes information priorities will drive actions and operations.

Information operations are tailored to the concerns of the populace and inform the public of successfully completed projects and improvements, not claims or future plans. For example, in Afghanistan, information operations might be employed to advertise that the infant mortality rate decreased 18% from 2001 to 2007 because of improvements in health services by the Afghan government.[4] All available media may be used including radio, publications, town meetings, etc., and health successes should be included in the talking points of commanders and civilian leaders.

Establish Civil Security/Civil Security Operations

Protecting key personnel and facilities is an essential stability task within the security sector.[5] This was an early key action for successful counterinsurgency campaigns in Tal Afar and Ramadi in Iraq.[6,7] U.S. forces seized the hospital from enemy control, denied refuge to enemy combatants, and extended the reach of essential services to the local populace. These actions were subsequently used in successful information operations to build legitimacy for the Iraqi government.

Establish Civil Control/Host Nation Security Forces

Establishing conditions for the host nation to perform security operations effectively[8] is related to the civil security and civil control line of effort. This includes building host nation capacity and establishing military-to-military programs. This can be implemented in the health sector through mentoring, partnering, training, and conducting combat health support with HN security forces (HNSFs).

As most developing countries have poor health systems, all levels and branches of the health sector should be targeted including all medical service functions. Security will benefit as HN personnel will be more likely to stay in their units and fight when they believe they will be properly treated if wounded. Disease and nonbattle injuries should be addressed to include training HN medical forces in preventive medicine to maintain a healthy fighting force.

The mission to develop HNSFs can be organized around these tasks—assess, organize, build or rebuild facilities, train, equip, and advise.[9] As in other lines of effort, every attempt should be made to create a sustainable program that will be ceded to the host nation as soon as viably possible.

Support to Governance

Effective local governance depends almost entirely on the ability to provide essential civil services to the people. Health care delivery is an essential public service.[10]

In Islamic culture, physicians enjoy high community status and respect and are often leaders. This is evidenced by prominent physician leaders both in friendly governments such as the recent Iraqi prime ministers Dr. Iyad Allawi and Dr. Ibrahim al-Jaafari as well as enemy leaders such as Dr. Ayman al-Zawahiri. High numbers of Iraqi physicians were assassinated in the early years of the Iraq war because of their prominence. The natural position of physicians as leaders in Islamic culture should be exploited at all levels through the common experiences and interests of medicine. Thus, local physicians may be natural targets for engagement and reconciliation cells.

Support to Economic and Infrastructure Development

Health sector development contributes to both long- and short-term economic development. Immediate short-term projects may include local improvements such as facility construction or renovation as well as needed jobs in health care delivery. Local medical contractors, such as pharmacists and medical suppliers, should be sought and patronized to develop economies. Microloan projects might finance local commerce in medical materiel. One long-term benefit of health sector development is contribution to a robust, prosperous economy.[11]

Where personnel needs are identified, such as the requirement for trained birth attendants, training programs will help develop necessary human capital. This may be coordinated locally through creative use of resources on hand. In Sinjar, Iraq, the U.S. battalion surgeon coordinated with the local hospital to conduct combat lifesaver training for Iraqi soldiers and border police. In addition to Iraqi soldiers and police trained in first responder techniques, a stronger relationship was forged between the Iraqi security forces and the Sinjar hospital.

Restore Essential Services

Tasks in essential services address the root causes of conflict, establish the foundation for long-term development, and ensure permanence of those efforts by institutionalizing positive change in society. Normally military forces support HN and civilian agencies with these efforts. When the HN cannot perform its roles, military forces support civilian agencies and organizations or execute these tasks directly. An exit strategy to turn over control to the HN government should underlie all stability operations.

In counterinsurgency or other non- or semipermissive environments, the military may be the leading agent in health sector activities. The preconflict baseline should be the minimum target for efforts in medical stability operations but may surpass this standard depending on the commander's guidance. It is imperative that medical stability operations are appropriately matched to a HN's ability to sustain them.[12]

Progress in the health sector demonstrates improvements in other sectors as well, including security, basic infrastructure, education, governance, and economic stabilization. Comprehensive improvements across all sectors are reflected in the health sector by short-term gains such as increased community use of health services or, over the longer term, improved outcomes such as lower infant mortality and infectious disease rates.

Restore Essential Services—Essential Stability Tasks

When U.S. forces restore and transition essential services to the HN government, they restore a tangible benefit for the populace, assist to establish governmental legitimacy, and decrease the effectiveness of insurgents (see Figure 3).[13]

When civilians are dislocated because of military operations, it may be necessary to provide direct medical care if nongovernmental humanitarian organizations (NGHOs) do not perform this responsibility. This should be planned ahead of operations and resourced accordingly. When appropriate,

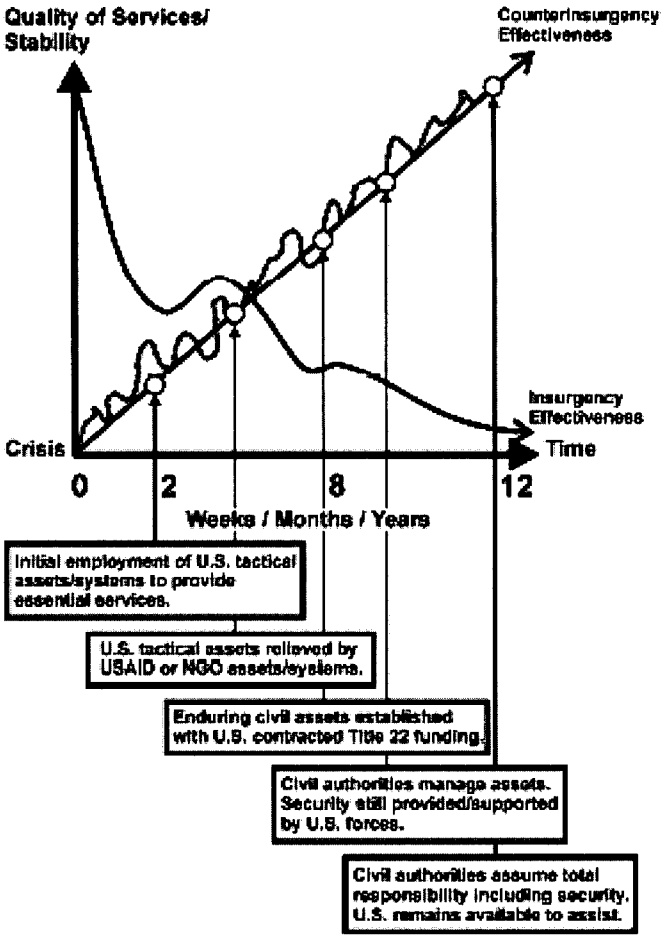

FIGURE 3. Comparison of essential services availability to insurgency effectiveness.[20]

coordinate with NGHOs for humanitarian assistance for large operations if necessary to support the population's medical needs.[14]

In areas of active conflict, military medicine may enable efforts by local and international aid organizations. This may include assessments of civilian medical and public health systems including infrastructure, medical staff, training and education, medical logistics, and public health programs. Early coordination and constant dialogue with other actors is key to achieve real success and successfully transition from military-led efforts to civilian organizations or the host nation.[15]

Essential tasks to support public health programs are closely related to tasks required to restore essential services. In many cases they complement and reinforce each other. These include:

(1) Assess public health hazards.
(2) Assess existing medical infrastructure including preventive and veterinary services, and medical logistics.
(3) Evaluate the need for additional medical capabilities.
(4) Repair existing civilian clinics and hospitals.
(5) Operate or augment operations of existing civilian medical treatment facilities.
(6) Prevent epidemics with immediate vaccinations.
(7) Support improvements to local waste and wastewater management.
(8) Promote and enhance HN medical infrastructure.[16]

Military activities to support education may include support for medical education, both at local and national levels.[17]

Restore Essential Services—Coordination

Possibly the most important action in medical stability operations is to coordinate with other health sector actors in the area. This is the key to success in medical stability operations at all levels from combatant commands to medical platoons. Local host nation medical authorities are primary, including local hospital and clinic directors as well as host nation government ministers and staff. Frequently other actors will be present in the area of interest such as provincial reconstruction teams with USAID representatives, IGOs, NGOs, and possibly private sector actors. Coordination should focus from the ground up to address local needs and win the loyalty of the populace.

Only a few actors will be available in an active insurgency whereas more actors will be available in more permissive environments, perhaps by orders of magnitude. Poor coordination fragments efforts, weakens health systems, and undermines governmental legitimacy by failing to address local priorities. By active coordination, the necessary understanding to conduct successful medical stability operations will be achieved. A key is to make this association a genuine partnership between USG counterinsurgents and HN authorities. Do not display the attitude that the USG has arrived to save the day. Respect local preferences and continually ask, "How do I know this effort matters to the local populace?"

A problem that sometimes arises in nonpermissive environments is lack of a clear leader. Seek to establish a lead actor, preferably a HN agency, but sometimes the military must take the lead in medical stability operations when overwhelming violence prevents civilians from acting. This may be necessary to gain the initiative. When this happens, seek to turn over the lead to a HN or civilian agency as soon as possible.

Be transparent with local leaders and other actors and consider the role of women and other cultural factors. Although the military sometimes conducts humanitarian missions, such as the disaster relief in Indonesia after the 2004 tsunami, medical stability operations in counterinsurgency are conducted for different reasons and are not humanitarian missions. Military aid is not neutral in counterinsurgency. Address the purpose of health sector development activities, which is intended to increase governmental legitimacy and improve stability. Transparency is especially important to prepare for transfer of responsibility and ensure that the original purpose is not lost.

Medical stability operations should be visible to the populace to achieve legitimacy for the local government. For example, in rebuilding the health sector in Japan after World War II, the USG provided milk to schoolchildren for lunches. The dual result was increased goodwill by Japanese citizens as well as improved nutritional status of Japanese children.[18] In 2005 in Tal Afar, Iraq, the hospital was secured by U.S. forces early in the operation to set the tone and communicate to citizens that the health sector belonged to the Iraqi government.

The targeting process links efforts to achieve effects that support lines of effort in the counterinsurgency campaign plan. Targeting meetings help to prioritize targets and determine the means of engaging them that best support the commander's intent and the operation plan. Pick low hanging fruit while developing operations with longer-term impact, e.g., mentoring or teaching programs, and then conduct information operations to broadcast achievements. Medical stability operations should be nested in the targeting process to achieve the commander's desired effect and planned in sufficient detail by combat arms officers so that unnecessary danger is avoided. In counterinsurgency, every operation is a potential combat operation. Competent leaders can expect insurgents to conduct attacks against restored services.

Restore Essential Services—Assessments

Assessment of HN needs should be one of the initial actions by counterinsurgents, to include meetings with local leaders and independent site assessments. Many methods of assessment are used currently, such as the Johns Hopkins Balanced Scorecard and the military's Tactical Conflict Assessment and Planning Framework. The latter should be used to conduct initial community assessments to determine whether health improvements are even desired by the local populace. If there are other actors in the area, coordinated assessments are likely to reveal the most complete picture, although every military unit should conduct its own assessment. Areas to assess include infrastructure, medical staff, training, education,

medical logistics, and public health and veterinary programs. Assessments should also attempt to uncover what cultural attitudes might be obstacles to medical stability operations.

One successful assessment method utilized a team of medical experts from a medical company to assess specific areas in the local hospital related to their military occupation specialty (MOS). In most medical companies, personnel include physicians, dentists, nurses, medical logistics officers, medical equipment repair technicians, and ambulance operators. See Table I for an example of assessment personnel and tasks. Ongoing and postmission assessments should be conducted to determine success of the operation and to inform planning for subsequent missions.

Restoring Essential Services—Actions

When an operation is indicated, medical stability operations should be directed at capacity building and sustainable interventions to build governmental legitimacy. It is always preferable for civilians to perform civilian tasks, particularly local authorities if available, even if a lower level of care is the goal. In a semipermissive environment with an adequate number of civilian actors, the military's role may be simply to support HN and civilian agencies and ensure security. Coordination may still be needed to determine necessary support of important facilitators, including logistical support, transportation, communications, intelligence support, administration, etc. In secure areas, the military's presence and participation may not be desired or needed and the military must be sensitive to that.

Of note, the anachronistic Medical Civic Action Program (MEDCAP) is generally not indicated, especially in urban areas. When U.S. medical personnel provide unnecessary direct care, they undermine HN legitimacy by displacing local services. Local healers and leaders may feel loss of face and honor and fail to support counterinsurgents as a result. Additional deleterious effects include unmet expectations by local citizens because of superficial treatments, crowds that may result in many turned away without treatment, and rules of eligibility that deny further services unless there is immediate threat to life, limb, or eyesight. MEDCAPs may have a role in rural areas without services but government or local medical service should never be displaced.

Where services are disrupted, a more appropriate model is the Coordinated Medical Engagement (CME), a joint coalition activity that promotes medical services by HN security forces. A recent mission in Iraq had 25 Iraqi providers and only two Americans. In this case, a link was established between the government and the populace, enforcing the public's perception of its government's ability to provide medical care.[19]

When donating medical materiel, it is important to consider the local ability to maintain it with replacement parts and repairs. In many cases, Western diagnostic equipment is beyond the scope of local abilities. Great care should be taken not to disrupt private enterprise where a medical supply market exists. When supplies or services are determined to be important in restoring essential services, every attempt to purchase these on the local market should be made.

Projects should aspire to sustainability. Coordination with local HN governmental and medical leadership is necessary to ensure actions meet local needs and link to the long-term development goals of the host nation. This will improve long-term impact and impart legitimacy to activities. When the military is the lead, it should begin planning from the beginning how to transition projects to nonmilitary actors with every effort to turn them over to HN agents. Early and consistent coordination is the key.

Developing human capital is essential to turn efforts over to the HN. Thus mentoring and training indigenous personnel is

TABLE I. Example of Assessment Personnel and Tasks.[6]

Group Focus	Group Members	Assessment Tasks
Administration	Medical company commander	Administration of hospital
	Support operations officer	Communications
	Brigade surgeon	
	Civil affairs officer	
Clinical	Field surgeon	Obstetrics, Pediatrics, Emergency room, Operating room
	Brigade nurse	Nursing procedures
	Support operations officer (supply and services)	Medical supply procedures
	Human intelligence specialist	Human intelligence collection
Physical plant and maintenance	Engineer	Structural integrity
	Medical platoon leader	Medical equipment
	Medical maintenance Technician	Medical maintenance procedures
	Interpreter	Equipment serviceability
Ancillary services	Medical platoon sergeant	Laboratory assessment
	Ambulance platoon NCO	Radiology assessment
	Lab and X-ray technician	Ambulance/emergency vehicle fleet assessment
	Interpreter	Ambulance utilization

critical to sustainability. When U.S. forces restore and transition essential services to the HN government, they remove one of the principal causes insurgents exploit and greatly increase governmental legitimacy.

Restoring Essential Services—Metrics

Postmission assessments in counterinsurgency operations determine completion of tasks and their impact, level of achievement of objectives, whether a condition of success has been established, whether the operation's end state was attained, and whether the commander's intent was achieved.[18] Indicators of success in medical stability operations may include simple measures such as increased patient census at the hospital. In 2005 in Tal Afar, Iraq, the hospital patient census fell by up to 95% when the local insurgency terrorized and controlled the city. After a successful offensive operation, locals began to return to the hospital and the patient census approached the preconflict baseline. The combat commander noted, "I could sense people's confidence and faith in security and their government had drastically improved. One indicator was when the female doctors came back to work and the hospital started seeing women and babies again."[5]

Other tactical and short-term measures might track performance as medical stability operations transition toward health sector development, e.g., polling data that demonstrates the population's perception of government-provided essential services is improved, percentage of children under 1 year that have been immunized, percentage of births with skilled attendance, percentage of the population with access to basic health services, percentage of health facilities that report deficiencies of essential drugs, etc.[21] Long-term success ultimately depends on the people taking charge of their own affairs and consenting to the government's rule.

As part of transition planning, key health metrics should be tracked from the outset to monitor whether essential services are improving. Inputs are the resources used in restoring essential services. Outputs are the first-order results including number of trained personnel and clinics built, etc. Outcomes are the conditions that directly impact the public, i.e., the consequences of activities, and are the preferred metrics in development. Improved outcomes demonstrate success in health sector development, such as improvements in water and sanitation conditions, infectious disease rates, mortality and morbidity rates, and food and nutrition conditions.[22] Health metrics should have HN buy-in, with monitoring and evaluation ultimately becoming the responsibility of HN health officials. In best cases, they will be determined and driven by the host nation.

CONCLUSION

Military medical personnel must be prepared to participate in stability operations in the health sector with the goal to increase governmental legitimacy. In nonpermissive conditions, such as active counterinsurgency, the military may be the leading actor until stability is established and leadership can be turned over to civilian actors for further health sector development. Principles of counterinsurgency and stability operations should be applied to essential tasks in the health sector across all lines of effort for maximal success. Transition from military- to civilian-led efforts in essential services should be planned from the beginning and executed as soon as possible.

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REFERENCES

1. U.S. Department of the Army: Field Manual 3-05.40, Civil Affairs, September 29, 2006, para 2-30. Washington, DC, Department of the Army, 2006.
2. U.S. Department of the Army: Field Manual 3-24, Counterinsurgency, December 15, 2006, para 5-19. Washington, DC, Department of the Army, 2006.
3. U.S. Department of the Army: Field Manual 3-07, Stability Operations, October 6, 2008, para 3-74. Washington, DC, Department of the Army, 2008.
4. The New York Times: 2007, Infant mortality rate in Afghanistan down 18 percent in 5 years. Available at http://www.nytimes.com/2007/04/26/world/asia/26iht-kabul.5.5458699.html; accessed August 1, 2009.
5. U.S. Department of the Army: Field Manual 3-07, Stability Operations, October 6, 2008, para 3-18. Washington, DC, Department of the Army, 2008.
6. Baker JB: Medical diplomacy in stability operations. Mil Rev 2007; (September-October):67–73.
7. Smith N, MacFarland S: Anbar Awakens: The Tipping Point. Mil Rev 2008; (March-April):41–52.
8. U.S. Department of the Army: Field Manual 3-07, Stability Operations, October 6, 2008, para 3-13. Washington, DC, Department of the Army, 2008.
9. U.S. Department of the Army: Field Manual 3-24, Counterinsurgency, December 15, 2006, para 6-32. Washington, DC, Department of the Army, 2006.
10. U.S. Department of the Army: Field Manual 3-07, Stability Operations, October 6, 2008, para 3-52. Washington, DC, Department of the Army, 2008.
11. U.S. Department of the Army: Field Manual 3-07, Stability Operations, October 6, 2008, para 3-62. Washington, DC, Department of the Army, 2008.
12. U.S. Department of the Army: Field Manual 3-07, Stability Operations, October 6, 2008, para 3-32, 3-33. Washington, DC, Department of the Army, 2008.
13. U.S. Department of the Army: Field Manual 3-24, Counterinsurgency, December 15, 2006, para 8-39, 8-41. Washington, DC, Department of the Army, 2006.
14. U.S. Department of the Army: Field Manual 3-07, Stability Operations, October 6, 2008, para 3-40. Washington, DC, Department of the Army, 2008.
15. U.S. Department of the Army: Field Manual 3-07, Stability Operations, October 6, 2008, para 3-47. Washington, DC, Department of the Army, 2008.
16. U.S. Department of the Army: Field Manual 3-07, Stability Operations, October 6, 2008, para 3-48. Washington, DC, Department of the Army, 2008.

17. U.S. Department of the Army: Field Manual 3-07, Stability Operations, October 6, 2008, para 3-49. Washington, DC, Department of the Army, 2008.
18. Jones SG, Hilborne LH, Anthony CR, et al: Securing Health: Lessons from Nation Building Missions, p 58. Santa Monica, CA, RAND Center for Domestic and International Health Security, 2006.
19. Multi-National Forces-Iraq: Coordinated Medical Engagement Treats Hundreds in Iraqi Family Village, 2009. Available at http://www.mnf-iraq.com/index.php?option=com_content&task=view&id=15621&Itemid=224; accessed January 25, 2009.
20. U.S. Department of the Army: Field Manual 3-24, Counterinsurgency, para 5-92, December 15, 2006. Washington, DC, Department of the Army, 2006.
21. Jones SG, Hilborne LH, Anthony CR, et al: Securing Health: Lessons from Nation Building Missions, pp 296–297. Santa Monica, CA, RAND Center for Domestic and International Health Security, 2006.
22. Jones SG, Hilborne LH, Anthony CR, et al: Securing Health: Lessons from Nation Building Missions, p 279. Santa Monica, CA, RAND Center for Domestic and International Health Security, 2006.